SPSO decision report

Case: **201002248, Lothian NHS board**
Sector: health
Subject: care of the elderly; nutrition; record-keeping; communication
Outcome: some upheld, recommendations

Summary

Mrs A was an elderly resident of a nursing home. She suffered from severe Alzheimer's disease and a range of other health problems. She was admitted to hospital for assessment as she was becoming increasingly agitated. At the time of admission, Mrs A had a wound on her left leg. She was in the hospital for just over two weeks, and was discharged back into the care of the nursing home, where she died about a month later.

Mrs A's son, Mr C, complained to the board about the care and treatment of his mother in hospital. He said that staff did not communicate with him adequately and that record-keeping was poor. The board upheld his complaint. They acknowledged gaps in record-keeping, that the scales used to weigh Mrs A were inaccurate and that communication was not good. They said they had taken steps to resolve these problems. After complaining to the board, Mr C remained dissatisfied. In his complaint to the Ombudsman he said that he was particularly concerned that Mrs A suffered unacceptable weight loss and inadequate wound care. He also complained of inadequate communication with Mrs A's family and poor record-keeping, in that the records contained conflicting information about where the wound on Mrs A's leg actually was.

We took advice on Mr C's complaint from one of our clinical advisers. Having seen Mrs A's nursing records, our adviser said that the care and treatment was reasonable. There was evidence that the board carried out appropriate nursing care. This included attending to hygiene needs, action, although initially minimal, to improve nutrition, eating and drinking, wound care and referral to a dietician and a speech and language therapist. In addition, the adviser said it was not unexpected that Mrs A may have lost weight as her condition deteriorated. Dementia sufferers have to be reminded to eat and drink, and in some cases they refuse to eat due to a loss in cognitive ability. It is common for older, frail people to lose weight in hospital but there are, of course, national nutrition standards in place. Having said this, our adviser was critical of the initial nutritional assessment. This noted that Mrs A was at low risk of malnutrition, so minimal action was taken at that time to improve her nutritional status. However, after considering all the evidence about this complaint, on balance we did not uphold it although we did make a recommendation on nutritional care. The adviser said that,

based on the available evidence, the assessment, care and treatment of Mrs A's leg wound was reasonable.

We did, however, uphold Mr C's complaints about communication and record-keeping. Hospital staff have a duty to keep the next of kin well informed. The records show that communication with Mr C appeared to have been poor. There were only two references to communicating with him during Mrs A's stay in hospital and there was no record of how Mr C wanted to be told about any change in his mother's condition. Given that Mrs A was incapable of making decisions Mr C should, for example, have been consulted about any treatment changes. On the complaint about record-keeping, we noted that on admission to the hospital, the initial nursing notes were completed by a student nurse. It appears that this was when the wound was noted to be on the right side rather than the left. The initial notes were countersigned by a charge nurse, but they continued to record the ulcer as being on the right side, and there was not enough cross-referencing to the wound chart. Our clinical adviser therefore said that aspects of the record-keeping were below an acceptable standard.

Recommendations

We recommended that the board:

- provide the Ombudsman with a copy of their nutritional care strategy as outlined in the NHS Quality Improvement Scotland Clinical Standards for Food, Fluid and Nutritional Care in hospitals. They should also provide details of the action plan appropriate for the hospital;
- ensure that sufficient communication tools are in place to ensure families and carers of patients at the hospital are informed of care and treatment issues. The board should also inform us of how, in practice, they will ensure families and carers will be better informed; and
- put in place a plan to monitor the quality of record-keeping at the hospital, to ensure records are kept in line with the principles outlined in the Nursing and Midwifery Council's record keeping guidance for nurses and midwives, and inform us of this plan and its results.